

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Embassy of Wyoming Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 50 N. Pennsylvania Ave. Wilkes Barre, PA 18701	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, resident and staff interviews, and review of facility dietary schedules, menus, and dietary records, it was determined the facility failed to consistently maintain sufficient dietary staff to effectively carry out the functions of the food and nutrition services department. This failure resulted in meals not being consistently served at palatable temperatures, the planned menu not being followed, and the food and nutrition services department not being maintained in a sanitary manner. Findings include: Review of the facility census revealed that on January 27, 2026, the facility census was 93 residents. Resident interviews conducted during the survey, which began on January 27, 2026, and concluded on January 30, 2026, revealed multiple concerns regarding the palatability of meals (the acceptability of food based on taste, texture, smell, and serving temperature). An interview with Resident 12 on January 27, 2026, at 12:00 PM revealed the resident reported food was frequently served cold and was not palatable. An interview with Resident 26 on January 27, 2026, at 12:30 PM revealed the resident did not like the food and was tired of being served meals that were cold. An interview with Resident 30 on January 27, 2026, at 12:45 PM revealed the resident stated the facility was aware he did not like the food and that meals were consistently cold. An interview with Resident 1 on January 28, 2026, at 10:30 AM revealed the resident generally liked the food but reported it was frequently not hot enough when served. Observation of the dietary department on January 28, 2026, at 12:00 PM, along with review of the facility's Daily Food Temperature Logs (recorded at each meal) for January 19 through January 28, 2026, revealed required meal temperatures were not consistently recorded. Breakfast and lunch temperatures were not documented on January 19, January 24, January 25, January 26, and January 27, 2026. Breakfast temperatures were also not recorded on January 28, 2026. Interview with the Food Service Director (FSD) at that time confirmed food temperatures were required to be recorded for each meal. A test tray evaluation was conducted on the Third Floor Nursing Unit on January 28, 2026, during the lunch meal. The test tray arrived at the nursing unit at 12:16 PM and consisted of a hot dog on a bun, corn, pork and beans, ice cream, milk, and coffee. The meal was served on Styrofoam plates, and coffee was served in a thermal mug. At 12:28 PM, after the last resident had been served, food temperatures were taken and revealed the following: Hot dog on bun measured 111 degrees Fahrenheit, below the required minimum hot holding temperature of 135 degrees Fahrenheit. Corn measured 106 degrees Fahrenheit, below the required minimum hot holding temperature of 135 degrees Fahrenheit. Pork and beans measured 122.6 degrees Fahrenheit, below the required minimum hot holding temperature of 135 degrees Fahrenheit. The hot dog, corn, pork and beans tasted only lukewarm and were not palatable. Review of dietary staffing schedules revealed limited staffing levels relative to the facility census and workload. On January 27, 2026, the dietary department schedule included one morning cook from 5:30 AM to 2:00 PM, one evening cook from 11:00 AM to 7:30 PM, one dietary aide from 6:30 AM to 1:00 PM, one dietary aide from 11:30 AM to 6:00 PM, one dietary aide from 4:00 PM to 8:00 PM, and one dietary aide assigned to assist with food delivery and storage (truck), with no specific hours identified. Review of dietary staffing schedules for January 28 and January 29, 2026, revealed similar staffing patterns, consisting of one morning cook, one evening cook, and three dietary aides covering staggered shifts, with no (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	increase in staffing despite meal service demands. Review of the planned menu for Week Four; Friday, revealed the planned dessert was a blonde chocolate chip brownie (non-chocolate counterpart to a traditional brownie). Observation of the tray line during the lunch meal on January 30, 2026, at 11:55 AM revealed the dessert served was a vanilla cake with a wet glazed frosting that did not appear appetizing. Interview with the Food Service Director at that time confirmed the planned dessert was not prepared and stated he had prepared the incorrect dessert. Interview with the Food Service Director on January 30, 2026, at 12:00 PM revealed that dietary staffing hours were reduced on December 30, 2025. The FSD confirmed dietary aides for the supper meal were reduced from three aides and a cook to two aides and a cook, despite no significant decrease in resident census. The FSD stated that due to the reduction in staffing, he frequently assists with cooking and production duties. The FSD further acknowledged there were sanitation concerns within the kitchen and confirmed he was behind on ensuring completion of required food temperature logs and cleaning assignments necessary to maintain a sanitary food service environment. Interview with the Nursing Home Administrator (NHA) on January 30, 2026, at 1:00 PM confirmed that on December 30, 2025, the corporation reduced total daily dietary staffing hours, including cooks, dietary aides, and the Food Service Director, from approximately 48 to 51 total hours per day to approximately 40 hours per day. The NHA acknowledged that following the reduction, the Food Service Director was required to cook and assist with meal production more frequently due to decreased staffing levels. The facility failed to maintain sufficient dietary staffing to ensure meals were prepared and served in a sanitary manner, served at palatable temperatures, and served as planned according to the established menu. Refer F804, F812 28 Pa. Code 201.14(a)(b) Responsibility of licensee. 28 Pa. Code 201.18 (b)(1) Management.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of select facility policy, and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of foodborne illness in the food and nutrition services department and failed to ensure that food storage in personal refrigerators was adequately monitored and maintained within safe temperatures to prevent foodborne illness for one resident with a personal refrigerator (Resident 5). Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). Review of the food and nutrition services department's Food Temperature Logs Policy last reviewed January 23, 2026, indicated that food temperatures of cold and hot items will be recorded on all menu items for meal service. Observation on January 27, 2026, at 10:00 AM, during the initial tour of the food and nutrition services department conducted with the Food Service Director (FSD), revealed multiple unsanitary conditions. Dirt and debris were observed on the floor throughout the kitchen. Two uncovered sheet cakes were observed on a rolling rack inside the walk-in refrigerator. The ceiling vent located above the ice machine was visibly dust covered, and two ceiling tiles adjacent to the dishwasher were heavily stained. Interview with the FSD at this time revealed the dishwasher had been broken for about one month. The FSD stated that paper products and plastic silverware were being used for meal service. The FSD confirmed that the three compartment sink (commercial kitchen fixture with three basins for manually washing, rinsing, and sanitizing dishes and utensils in distinct stages, following health code standards by using hot, soapy water for washing dishes at a temperature of 110 degrees Fahrenheit, clean water for rinsing, and a chemical sanitizer, with items then air dried on a nearby drainboard to prevent contamination) was being utilized to clean and sanitize the non-disposable kitchen equipment. Review of facility provided documentation revealed the dishwasher became inoperable on November 21, 2025. Documentation further showed a lease for a replacement dishwasher was signed on November 24, 2025, and the facility was awaiting delivery and installation of the new unit. Observation on January 30, 2026, at 10:25 AM, revealed the new dishwasher was in place but not operational, as it was awaiting electrical service. Observation on January 28, 2026, at 12:00 PM, revealed an accumulation of dirt and debris underneath the tray line area. Observation on January 30, 2026, revealed four food delivery carts identified as clean had visible food stains on both the interior and exterior surfaces. Observation of the steam table at that time revealed water in the individual wells contained food debris from prior meals. The FSD stated the steam table water was changed weekly. Review of facility records revealed there were no documented cleaning schedules available for the months of December 2025 or January 2026. During an interview on January 30, 2026, at 10:40 AM, the FSD confirmed the food and nutrition services department was expected to be maintained in a sanitary manner and that facility policies and procedures were to be followed to ensure food safety and prevent foodborne illness. Review of the facility's Daily Food Temperature Logs from January 19 through January 28, 2026, revealed incomplete documentation. Breakfast and lunch food temperatures were not recorded on January 19, January 24, January 25, January 26, and January 27, 2026. Breakfast temperatures were also not recorded on January 28, 2026. During an interview conducted on January 28, 2026, the FSD confirmed food temperatures were required to be monitored and recorded at each meal. Review of the facility's Resident Refrigerators policy last reviewed January 23, 2026, revealed that it was the policy of the facility to ensure safe and sanitary (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	use of any resident owned refrigerator. Leftover food will be dated upon receipt and discarded within three days. Nursing and housekeeping were to discard any food that was out of compliance during the minimal weekly checks, which was to include assessing properly dated food items and discarding what was outdated, and monitor refrigerator temperatures. During an interview on January 27, 2026, at 11:00 AM, Employee 7 Licensed Practical Nurse stated Cooler Temperature Logs were posted on the outside of resident refrigerators and nursing or housekeeping staff were responsible for monitoring and documenting internal refrigerator temperatures daily. Observation of Resident 5's personal refrigerator located in the resident's room on January 27, 2026, at 11:00 AM, revealed a covered plastic container of food without a date indicating when it was placed in the refrigerator. Employee 7 was unable to identify how long the food had been stored or whether the three-day discard timeframe had been exceeded. Observation of the Cooler Temperature Log posted on the outside of Resident 5's refrigerator on January 27, 2026, at 11:00 AM, revealed the last documented internal refrigerator temperature was recorded on August 1, 2025. During an interview on January 28, 2026, at 9:00 AM, the nursing home administrator was unable to provide additional information to demonstrate staff consistently monitored and documented resident refrigerator temperatures or ensured food was properly labeled and discarded to prevent foodborne illness. Refer F802 28 Pa Code 201.18 (e) (2.1) Management. 28 Pa Code 211.6(f) Dietary services. 28 Pa Code 211.10 (a)(d) Resident care policies. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, review of documentation provided by the facility, select policies, and staff interview, it was determined that the facility failed to develop and implement a water management program, identify potential factors related to the prevalence of urinary tract infections, and implement interventions based on these factors to decrease the occurrence and further failed to ensure compliance with facility policy to reduce the spread of infection was consistently implemented, including observations made on one out of two nursing units (Second Floor Nursing Unit). Findings include: According to the Centers for Disease Control (CDC) Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings, September 30, 2025, Legionnaires' disease is a serious type of pneumonia caused by bacteria called Legionella that live in water. People can get sick when they inhale water containing Legionella from building water systems or devices that are not adequately maintained. A water management program should identify areas or devices in a building where Legionella might grow or spread to people in order to reduce that risk. Legionella water management programs are now an industry standard for large buildings in the United States. A review of the facility policy titled Water Management Program, last reviewed by the facility on January 23, 2026, revealed it is the policy of the facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens in the facility's water systems on a nationally accepted standard (e.g., CDC). It is the facility's policy to establish a water management team to develop and implement the facility's water management program, maintain documentation that describes the facility's water system, and conduct a risk assessment annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. During an interview on January 30, 2026, at 10:00 AM, the Infection Preventionist was unable to provide documented evidence that the facility established a water management team to develop and implement the facility's water management program. During an interview on January 30, 2026, at 12:30 PM, the Nursing Home Administrator was unable to provide documented evidence describing the facility's water system or documentation showing that the facility conducted an annual risk assessment to identify where Legionella or other opportunistic waterborne pathogens could grow and spread within the facility's water system. A urinary tract infection is an infection involving any part of the urinary system, including the bladder or kidneys. Review of the Infection Control Logs dated September 2025 revealed that 50 percent of the facility-acquired urinary tract infections were caused by Escherichia coli and or Proteus mirabilis. These bacteria are commonly found in stool and are associated with inadequate perineal care, which is the cleaning of the genital and anal areas. Review of the Infection Control Log dated October 2025 revealed the percentage of facility-acquired urinary tract infections caused by Escherichia coli and or Proteus mirabilis increased to 87.5 percent. Review of the Infection Control Logs dated November 2025, and December 2025 revealed the rates of facility-acquired urinary tract infections associated with Escherichia coli and Proteus mirabilis were 60 percent and 66.6 percent, respectively. Review of Infection Control Logs dated September 2025 through December 2025 revealed a total of 18 facility-acquired urinary tract infections caused by Escherichia coli and or Proteus mirabilis. Twelve of the affected residents resided on the third floor nursing unit. During an interview on January 30, 2026, at 1:00 PM, the Infection Preventionist was unable to provide evidence that the facility analyzed potential contributing factors related to the increased percentage of urinary tract infections or that reasonable interventions related to staff practices or resident self-care were identified and implemented. An interview with the Infection Preventionist on January 30, 2026, revealed that the facility did not audit staff technique with perineal care to ensure it was properly performed in an effort to potentially reduce the prevalence of causative organisms. In addition, the Infection Preventionist indicated that they did not directly audit call bell response to residents who were incontinent of bowels or needed assistance with bowel hygiene to determine if timely care was rendered to reduce the percentage of infections related to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Escherichia coli and Proteus mirabilis. The Infection Preventionist did not analyze if any of the residents with Escherichia coli or Proteus mirabilis were involved in self-care, thus representing education that would need to be provided directly to the residents to reduce occurrence. The Infection Preventionist was unable to answer why over 66% of the facility-acquired urinary tract infections occurred on the third floor. A review of a hand hygiene audit tool for general practice revealed that on September 18, 2025, this audit was completed to ensure staff were observed properly sanitizing hands and practicing good hygiene techniques between residents. The Infection Preventionist indicated this was completed to monitor staff compliance and to reduce infections including urinary tract infections caused by Escherichia coli and Proteus mirabilis. Although from the time of the audit on September 18, 2025, and review of the Infection Control Log for the month of October 2025, there was a 37.5% increase in the prevalence of urinary tract infections related to Escherichia coli and Proteus mirabilis. The Infection Preventionist was unable to indicate based on this data what additional interventions were implemented or what the facility determined to be the causative factor for this significant increase. During an interview on January 30, 2026, at 1:00 PM the Infection Preventionist was unable to provide evidence that the facility identified potential factors into the increased percentage of urinary tract infections and that reasonable interventions associated with the analysis of staff/resident practice were identified as potential causes. Observation of the Second Floor Nursing Unit on January 27, 2026, at 11:30 AM revealed ten wall-mounted hand sanitizing units. Upon attempt to use these units, none dispensed hand sanitizing solution. A review of the facility's hand hygiene policy, last reviewed January 23, 2026, revealed that staff was to perform hand hygiene between resident contact. Observation of Employee 8, Nurse Aide (NA) and Employee 9, NA on January 28, 2026, at 12:30 PM revealed that these employees were delivering meal trays to the residents on the second floor in their respective rooms. Further observation revealed that neither of these employees washed/sanitized their hands between resident rooms. Employee 8, NA, was noted to insert her fingers inside a Styrofoam cup, fill the cup with a liquid beverage, and take it into a resident room. An interview with Employee 8, NA, on January 29, 2026, at 9:00 AM, confirmed that she does not always wash/sanitize hands between residents; however, she would do so more readily if the sanitizing stations on the walls were functioning. An interview with the director of nursing on January 29, 2026, at 9:30 AM, confirmed that all sanitizing stations were fixed and that staff were to cleanse hands between each resident. The facility failed to establish and implement a water management program to reduce the risk of Legionella and other waterborne pathogens, failed to identify potential factors related to the prevalence of urinary tract infections, and implement interventions based on these factors to decrease the occurrence and further failed to ensure compliance with facility policy to reduce the spread of infection was consistently implemented. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observations, review of clinical records, facility policy, and staff interviews, it was determined the facility failed to ensure residents' call lights were accessible to reasonably accommodate a resident's need for assistance for three out of 23 residents sampled (Residents 3, 29, 7, and 63). Findings include: Review of the facility policy titled Call Lights: Accessibility and Timely Response last reviewed by the facility on January 21, 2026, indicated that all staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of the resident and secured as needed. Observation on January 27, 2026, at 11:43 AM revealed two staff members exiting Resident 3's room after providing care. Resident 3 was awake and lying in bed. The call bell was observed on the floor under the bed and was not within the resident's sight or reach. Review of Resident 3's care plan dated June 24, 2021, indicated the resident was at-risk for falls with a planned intervention to ensure the resident's call light was within reach. Observation on January 27, 2026, at 11:47 AM revealed Resident 29 was seated in her wheelchair on the left side of the bed. The call bell was observed on the floor on the right side of the bed and was not within the resident's sight or reach. Review of Resident 29's care plan dated November 6, 2025, indicated the resident was at-risk for falls with a planned intervention to ensure the call light was within reach at all times. Observation on January 27, 2026, at 11:50 AM revealed Resident 7 was seated on the edge of the right side of the bed. The call bell was observed lodged under the bedframe and not within the resident's sight or reach. Review of Resident 7's care plan dated June 5, 2025, indicated the resident was at-risk for falls with a planned intervention to ensure the call light was within reach. An interview with Employee 2 (Nurse Aide) on January 27, 2026, at 12:00 PM confirmed the observations and acknowledged Residents 3, 29, and 7 did not have access to a call bell to request staff assistance. Observation on January 28, 2026, at 10:28 AM revealed Resident 3 lying in bed. The call bell was draped over the top mattress on the left side and wedged into the bedframe. The call bell was positioned above the resident's head and not within the resident's reach. Observation on January 28, 2026, at 10:36 AM revealed Resident 29 seated in a wheelchair on the left side of the bed. The call bell was observed on the floor on the left side of the bed and not within the resident's sight or reach. An interview with Employee 3 (Licensed Practical Nurse) on January 28, at 10:40 AM confirmed the observation and stated that Residents 3 and 29 did not have access to a call bell for staff assistance. Employee 3 further confirmed that facility practice requires call bells to be placed within residents' reach at all times. Observation on January 28, 2026, at 9:00AM revealed Resident 63 lying in bed and yelling out for assistance. The call bell was observed on the floor under the resident's bed and was not within the resident's sight or reach. Interview with Employee 6 (LPN) who responded upon surveyor request to provide help to Resident 63 confirmed the observation of the call bell under the resident's bed out of the resident's reach. Employee 6 repositioned Resident 63 who then stopped yelling. Employee 6 confirmed that facility practice requires staff to ensure that call bells are placed within residents' reach at all times. Review of Resident 63's care plan last reviewed December 27, 2025, indicated the resident was at risk for falls with a planned intervention to ensure the call light was within reach. Interview with the Nursing Home Administrator on January 28, 2026, at 1:00 PM confirmed that call bells were to be kept within reach for all residents. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing Services. 28 Pa. Code 201.29 (a) Resident Rights. 28 Pa. Code 211.10 (c)(d) Resident Care Policies.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and resident and staff interviews, it was determined the facility failed to provide a clean, comfortable, and homelike environment for residents, including concerns expressed by six out of six residents during a resident group interview (Residents 46, 56, 71, 77, 83, and 94) and four out of 23 sampled residents (Residents 9, 14, 20, and 52). Findings include: An observation on January 27, 2026, at 12:07 PM in resident room [ROOM NUMBER] revealed dust, food pieces, debris, and dirt on the floor and under the window-side resident bed. An observation on January 27, 2026, at 12:09 PM in resident room [ROOM NUMBER] revealed water discoloration stains and pooling near the door side bed. Food pieces and dirt were observed under the door-side bed. The resident toilet was observed with brown stains and discolorations on the seat. The toilet dispenser roll was observed with a 2-inch gap between the metal dispenser and the wall, exposing the inside of the wall. [NAME] debris from the wall was observed on the floor underneath the toilet paper dispenser. An observation on January 27, 2026, at 12:20 PM, revealed the first floor main dining room felt cold. The wall thermostat in the main dining room was set to heat the room to 75 degrees Fahrenheit, but the wall thermometer was indicating the room temperature was 65 degrees Fahrenheit. An interview on January 27, 2026, at 12:20 PM with Residents 20 and Resident 52 who were present in the dining room for lunch stated that it is often cold in the main dining room. Resident 9 was observed to be wrapped in a blanket and stated that she needed to go back to her room right after she eats because it is too cold in the dining room. Resident 14, who was also in the main dining room for lunch, stated, Hey, turn on the heat. During an interview on January 27, 2026, at 12: 22 PM the director of maintenance confirmed that the heat was set at 75 degrees Fahrenheit but was not turning on and needed to be repaired. An observation on January 27, 2026, at 12:25 PM in resident room [ROOM NUMBER] revealed a blue fall mat with brown and gray liquid and discoloration stains. An observation on January 27, 2026, at 12:34 PM in resident room [ROOM NUMBER] revealed a broken toilet dispenser roll. The ceiling above the window-side bed was observed with a line of chipped paint extending for 3 feet. A follow-up observation on January 28, 2026, at 8:55 AM revealed that the first-floor dining room felt cold. The wall thermostat in the main dining room was set to heat the room to 76 degrees Fahrenheit, but the wall thermometer was indicating the room temperature was 63 degrees Fahrenheit. During an additional observation on January 28, 2026, at 9:15 AM, the nursing home administrator confirmed that the temperatures of four walls in the first-floor dining room were 64 degrees Fahrenheit, 62.6 degrees Fahrenheit, 61.2 degrees Fahrenheit, and 62.96 degrees Fahrenheit, respectively. During a resident group interview on January 28, 2026, at 10:00 AM, six out of six residents (Residents 46, 56, 71, 77, 83, and 94) indicated they have a concern about the cold temperatures in the facility's dining room. An observation on January 28, 2026, at 12:22 PM in the third-floor Resident Pantry revealed a counter with pink liquid discoloration stains on the counter and dripping down the brown cabinets, dirt and debris pieces on the floor, a broken electrical outlet, and three ceiling blocks with 1 foot brown water discolorations, and a missing ceiling block. Additionally, the heating/cooling unit was observed with dozens of food pieces inside the radiator fins. An observation on January 28, 2026, at 12:30 PM outside the third-floor Resident Dining room revealed white handrails with chipped and peeling paint. During an interview on January 30, 2026, at 12:30 PM, the above findings were reviewed with the nursing home administrator (NHA). The facility failed to provide a clean, comfortable, and homelike environment for residents. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, a review of select facility policy, and resident and staff interviews, it was determined that the facility failed to ensure the required information and resources were made available to residents for filing grievances with the facility and for filing grievances with independent entities, including six out of six residents interviewed during a resident group meeting (Residents 46, 56, 71, 77, 83, and 94). Findings included: A review of the facility policy titled Resident and Family Concerns, last reviewed by the facility on January 21, 2026, revealed it is the policy of the facility to support each resident's and family member's right to voice grievances without discrimination, reprisal, or fear of discrimination or reprisal. Notices of resident's rights regarding grievances will be posted in prominent locations throughout the facility. Information on how to file a grievance or complaint will be available to the resident. A review of the facility policy titled Resident and Family Concerns revealed the facility failed to include the following required information in the policy: the contact information of the grievance official, the contact information of independent entities with whom grievances that may be filed, and the time frame that residents may reasonably expect completion of the review of the grievance and a written decision regarding his or her grievance. During a resident group interview on January 28, 2026, at 10:00 AM, six out of six alert and oriented residents (Residents 46, 56, 71, 77, 83, and 94) in attendance indicated they were not informed about the facility grievance process and did not know how to file a grievance. The residents in attendance were unable to explain the grievance process or purpose. Residents 46, 56, 71, 77, 83, and 94 were unable to identify the grievance official and did not know how to file a grievance or how to file a complaint with independent entities such as the local ombudsman or pertinent state agencies. An observation on January 28, 2026, at 10:45 AM of the third-floor dining room revealed an unlabeled black mailbox. There was no information explaining the function or purpose of this box. During an interview on January 28, 2026, at 10:55 AM, Employee 3, LPN, confirmed there was an unlabeled black mailbox in the third-floor dining room. She explained that she believed the box was for resident grievances. Employee 3, LPN, confirmed there was no posted information explaining the function or purpose of the box. During an interview on January 30, 2026, at 12:30 PM, the above findings were reviewed with the nursing home administrator (NHA). The NHA was unable to explain why Residents 46, 56, 71, 77, 83, and 94 indicated they had no knowledge of the grievance process. The facility failed to ensure the required information and resources were made available to residents for filing grievances with the facility and for filing grievances with independent entities. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29(a) Resident rights.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, observations, and resident and staff interviews, it was determined the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of residents, including experiences expressed by 1 out of the 23 sampled residents (Resident 50) and as expressed by residents during a resident group interview (Residents 46, 56, 71, 77, 83, and 94) Findings include: A clinical record review revealed Resident 50 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A care plan initiated May 1, 2024, identified Resident 50 as having a chronic decline in intellectual functioning related to dementia. Interventions included encouraging small group activities. During an interview on January 27, 2026, at 12:05 PM, Resident 50's representative indicated that Resident 50 loved music, arts and crafts, coloring, drawing, and painting. Resident 50's representative explained that she has not observed Resident 50 in any activities when she visits and believes that she would benefit from participation in activities she enjoyed. Observation of the third-floor secured memory care unit on January 27, 2026, between 10:45 AM and 12:15 PM revealed no group or individual activities in progress. The activity room was empty, and there was no evidence that activities were occurring in other common areas on the unit. Observation on January 27, 2026, at 11:10 AM in the Sunny Side Cafe dining room revealed five residents present; four were seated in wheelchairs and one resident was standing while bent forward at the waist A television was on; however, no residents appeared engaged with the programming. No staff were present. Further observation of the third floor between 10:45 AM and 11:55 AM revealed that of 20 residents residing in rooms 315-326, 13 residents were observed in bed, and three residents were seated in wheelchairs in their rooms. Only four residents were observed outside of their rooms. Review of the activity calendar for January 27, 2026, indicated a scheduled 11:00 AM Hot Chocolate Bar activity in the activity room; however, no such activity was conducted on the third-floor memory care unit. Observation on January 28, 2026, between 9:35 AM and 10:50 AM again revealed no activities being conducted on the third-floor memory care unit. The activity room remained empty, and no staff were observed providing one-to-one activity interventions. The activity calendar for January 28, 2026, listed Morning News and Music at 9:00 AM and Guided Meditation at 11:00 AM in the activity room; however, these activities were not observed on the third-floor memory care unit. During an interview on January 28, 2026, at 10:20 AM, Employee 3 (Licensed Practical Nurse) stated there were no specific activities being provided on the third-floor memory care unit. Employee 3 reported the facility previously had an activity staff member assigned to the unit who provided daily group and individual activities; however, the position had been eliminated over a month ago. Employee 3 stated current activities were primarily facility-wide and only select residents from the secured unit were able to attend the activities on the first floor based on safety considerations. During an interview on January 28, 2026, at 10:40 AM, Employee 1 (Activity Director) confirmed the Memory Care Coordinator activity position was eliminated mid December 2025. Employee 1 stated group activities were no longer provided on the third-floor memory care unit and residents attended activities off the secured unit only as deemed appropriate. Employee 1 reported there were two activity staff members Monday through Friday and one staff member on weekends. At the time of the survey, the facility census was 93 residents, with 46 residents residing on the third-floor secured memory care unit. During a resident group interview on January 28, 2026, at 10:00 AM, six out of six alert and oriented residents (Residents 46, 56, 71, 77, 83, and 94) indicated dissatisfaction with the facility's activities program. Residents indicated that they do not meet as a resident council (an organized, independent group of residents who meet regularly to discuss concerns, share opinions, and advocate for improvements in their quality of life and care) or gather to (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discuss recommendations or improvements. Residents 46, 56, 71, 77, 83, and 94 indicated that they are not asked what type of groups and activities they enjoy. During the group interview Resident 56 indicated that there are very few activities available and she would like to have more activities. During the group interview Resident 77 indicated there are no activities on the third floor. She explained that they have to go downstairs to participate in bingo. She indicated that she would like the facility to offer arts and crafts activities. Resident 77 explained that in the past they would play games like Uno and have games available all day but was upset because the facility stopped offering Uno and providing access to the games. She also indicated that reminiscing activities were offered and enjoyed in the past, but the facility no longer provides that activity. During the group interview Resident 46 indicated that she would like to participate in arts and crafts, music, and memory game activities. She explained that there are not enough activities available. During the group interview Resident 71 indicated that there are no activities on the third floor and there have not been for at least a month. She explained that she would like to have more activities available. During the group interview Resident 94 indicated that she would like to participate in arts and craft, music, and cooking activities, but explained that the facility does not offer many activities. During the group interview Resident 83 indicated the only activity available was bingo. She explained that there are no activities on the second floor. Resident 83 indicated that in the past she enjoyed the reminiscing groups where residents talked about positive experiences from the past. She explained that she would like to have the opportunity to participate in these groups again. During an interview on January 30, 2026, at 12:30 PM, the above findings were reviewed with the Nursing Home Administrator (NHA). The NHA confirmed the Memory Care Coordinator activity position was eliminated on December 10, 2025. The facility failed to provide an ongoing program of activities that met residents' interests and supported their physical, mental, and psychosocial well-being. Refer F680 28 Pa. Code: 201.18 (b)(3)e(2) Management 28 Pa. Code 211.12(d)(3) Nursing services.		

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on observations, review of facility documentation, review of personnel records, and interviews with staff, it was determined the facility failed to ensure the activities program was directed by a qualified professional for one of one activities personnel files reviewed (Employee 1). Findings include: Review of facility documentation revealed the job description for Activity Director stated the primary purpose of the job position is to plan, organize, develop, direct and implement the overall operation of the Activity Department in accordance with current, federal, state, and local standards, guidelines and regulations, our established policies and procedures, and as may be directed by the Administrator, to assure that an on-going program of activities is designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Continued review of the job description revealed the Activity Director is required to meet one of the following qualifications: be a qualified therapeutic recreation specialist or an activities professional who is licensed by this state and is eligible for certification as a recreations specialist or as an activities professional; or must have, as a minimum, two years' experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting; or must be a qualified occupational therapist or occupational therapy assistant; or must have completed a training course approved by the state. Review of the facility's Department Heads Contact List revealed that Employee 1 (Activity Director) was identified as the Recreation Director. Review of Employee 1's personnel file revealed the employee was hired on December 9, 2025, as the Activity Director. Review of the employee's education and work history revealed no evidence that Employee 1 was a certified therapeutic recreation specialist, had prior experience in a therapeutic activities program, was a qualified occupational therapist or occupational therapy assistant, or had completed a state-approved training course. Observation on January 29, 2026, at 9:00 AM revealed Employee 1 was overseeing an activities program with residents in the activities room. During an interview on January 29, 2026, at 9:26 AM the Nursing Home Administrator confirmed that the Activity Director had not completed any credentialing or training courses required to qualify as a therapeutic recreation specialist, was not recognized as an activities professional by an accrediting body, and did not meet the minimum qualifications for the position. Refer to F679 28 Pa. Code 201.18 (e)(6) Management. 28 Pa. Code 201.19(3) Personnel policies and procedures.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews, review of manufacturer storage guidelines, and review of facility policy, it was determined that the facility failed to ensure drugs and biologicals were properly stored and that expired or improperly labeled medications were removed from use. Specifically, the facility failed to maintain required refrigeration temperatures for injectable medications used to manage blood sugar levels and failed to discard expired or improperly labeled medications, affecting 11 residents medications in two of two medication rooms observed. (Residents 5, 9, 10, 25, 42, 66, 72, 78, 85, 92, and 94). Findings include: A review of manufacturer storage guidelines for injectable blood glucose-lowering medications, including Glargine, Humalog, Trulicity, Lantus, Novolog, and Lispro (injectable medications used to treat diabetes by lowering blood sugar levels), revealed that these medications require refrigerated storage at temperatures between 36 and 46 degrees Fahrenheit to maintain medication stability and effectiveness. Manufacturer guidance further specifies that these medications must not be frozen, as freezing can damage the medication and render it ineffective or unsafe. Review of the facility's Storage of Medications policy dated January 23, 2026, revealed that the facility shall not use discontinued, outdated, or deteriorated drugs/biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station at the appropriate temperature. During an observation of the second-floor medication room on January 27, 2026, at 9:30 AM, a medication refrigerator was observed with an internal thermometer registering 34 degrees Fahrenheit, which is below the manufacturer-required storage range. The following vials of injectable blood glucose-lowering medications were stored in this refrigerator: Resident 5 -one vial of injectable Lantus Resident 9 -one vial of injectable Novolog Resident 10 -one vial of injectable Novolog Resident 25 -one vial of injectable Trulicity Resident 72 -one vial of injectable Novolog Resident 78 -one vial each of injectable Lispro, Novolog, and Lantus Resident 85 -one vial of injectable Novolog Storage of injectable medications below the required temperature range increases the risk that the medication may lose effectiveness, which could result in inadequate blood sugar control. During an observation of the third-floor medication room on January 27, 2026, a medication refrigerator was observed with an internal thermometer registering 30 degrees Fahrenheit, indicating freezing-level temperatures. The following vials of injectable blood glucose-lowering medications were stored in this refrigerator: Resident 42 -one vial of injectable Lantus Resident 66 -one vial of injectable Lantus Resident 92 -one vial of injectable Novolog Resident 94 -one vial each of injectable Novolog and Lantus Exposure of injectable medications to freezing temperatures is inconsistent with manufacturer guidelines and may compromise medication integrity. During an observation of the stock medication cabinet located at the second-floor nursing station on January 27, 2026, at 9:30 AM, the following medications were observed available for use despite being expired or improperly labeled: Antacid tablets expired December 2025 Zinc ointment expired October 2025 One open vial of Simethicone capsules with no documented date of opening One open vial of Aspirin 81 mg with no documented date of opening An interview with the director of nursing on January 27, 2026, at 9:30 a.m., confirmed that the above injectable blood glucose-lowering agents were to be stored in the refrigerator and maintained between 36-46 degrees Fahrenheit. In addition, all medications once opened should be dated at that time, and any expired medications are to be discarded. 28 Pa. Code 211.12 (c)(d)(3) (5) Nursing services. 28 Pa. Code 211.10(d) Resident care policies.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, review of select facility policies, test tray evaluation, review of facility-provided documentation, and resident and staff interviews, it was determined the facility failed to ensure foods were served at safe and palatable temperatures for four of 23 residents sampled (Residents 12, 26, 30, and 1). Findings included: According to the federal regulation 483.60(i)-(2) Food safety requirements, the definition of Danger Zone, found under the Definitions section, is food temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit that allow rapid growth of pathogenic microorganisms that can cause foodborne illness. Review of the facility Safe Food Handling Practices Policy last reviewed January 23, 2026, revealed that hot food must be held at 135 degrees Fahrenheit or higher and cold foods must be held at 41 degrees or lower. During an observation of the dietary department on January 26, 2026, at 10:00 AM, the facility's dishwasher was observed to be inoperable. During an interview at that time, the Food Service Director (FSD) stated the dishwasher had been broken for approximately one month and confirmed that disposable paper products and plastic silverware were being used for resident meal service. A review of facility-provided information revealed the dishwasher malfunctioned and became inoperable on November 21, 2025. A review of Resident Food Committee Meeting Minutes dated December 25, 2025, revealed residents expressed concerns that the dishwasher had not yet been repaired and reported that food was being served cold. A subsequent review of Food Committee Meeting Minutes dated January 14, 2026, revealed residents continued to voice concerns that the dishwasher remained unrepaired and requested that hot foods be served on plates rather than Styrofoam. During an interview on January 27, 2026, at 12:00 PM, Resident 12 stated that meals were frequently served cold and not palatable and reported meals being served on Styrofoam containers for several months due to the broken dishwasher. During an interview on January 27, 2026, at 12:30 PM, Resident 26 stated dissatisfaction with the food and reported being tired of receiving cold meals. During an interview on January 27, 2026, at 12:45 PM, Resident 30 stated the facility was aware he did not like the food and reported that meals were always cold. During an interview on January 28, 2026, at 10:30 AM, Resident 1 stated they liked the food but reported it was frequently not hot enough. A test tray evaluation was conducted on the Third Floor Nursing Unit on January 28, 2026, during the lunch meal. The test tray arrived on the unit at 12:16 PM and consisted of a hotdog on a bun, corn, pork and beans, ice cream, milk, and coffee. The meal was served in Styrofoam containers, with coffee served in a thermal mug. At 12:28 PM, after the last resident on the unit was served, food temperatures were measured and recorded as follows: Hotdog on bun: 111 F (below the required minimum of 135 F) Corn: 106 F (below the required minimum of 135 F) Pork and beans: 122.6 F (below the required minimum of 135 F) The hot dog, corn, pork and beans tasted only lukewarm and were not palatable. During an interview on January 28, 2026, at 1:15 PM, the Food Service Director confirmed that meals are required to be served at safe and appetizing temperatures and acknowledged that the test tray temperatures did not meet facility policy or regulatory requirements. A review of Test Tray Audits completed by the Registered Dietitian (RD) on November 21, 2025 (third floor lunch), November 28, 2025 (third floor lunch), December 4, 2025 (second floor lunch), December 12, 2025 (third floor lunch), January 9, 2026 (third floor lunch), and January 15, 2026 (second floor lunch) revealed that multiple hot food items were documented as not being served at palatable temperatures. During an interview on January 29, 2026, at 1:40 PM, the Registered Dietitian confirmed that complaints related to cold food had increased since the dishwasher became inoperable. During an interview on January 29, 2026, at 2:30 PM, the Nursing Home Administrator confirmed the facility failed to ensure meals were consistently served at temperatures that were palatable and in accordance with regulatory requirements. Refer F80228 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(3) Management.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility-provided documentation, and employee interviews, it was determined the facility failed to ensure the accuracy and completeness of resident medical records for one of 3 closed records (Resident 98). Findings include: Review of the clinical record revealed that Resident 98 was admitted to the facility on [DATE], and subsequently transferred to the emergency department on November 28, 2025. Following a fall on November 25, 2025, neurological check assessments (routine monitoring for signs and symptoms of head or brain injury) were initiated for Resident 98. Review of these neurological assessments revealed a total of 21 assessments were documented as completed. However, the electronic clinical record indicated the neurological assessment documentation was not finalized or locked until January 7, 2026. A lock date represents the point at which documentation is finalized and made read-only to prevent further alteration. Further review revealed that 13 of the 21 neurological assessments were not signed as completed until after Resident 98 had already been transferred to the emergency department on November 28, 2025. Additional record review revealed the presence of late-entry progress notes. A progress note dated November 27, 2025, at 11:29 AM documented that Resident 98 was awake, alert, oriented to self, and confused per baseline; however, the electronic record indicated this note was created on November 30, 2025, at 2:31 PM. Similarly, a progress note dated November 28, 2025, at 10:37 AM documented that the resident was awake, alert, oriented to self, and confused per baseline, yet the electronic record showed this note was created on November 30, 2025, at 2:38 PM. In addition, the facility provided a certified registered nurse practitioner (CRNP) progress note dated November 26, 2025, and signed at 5:27 PM. This note was not uploaded into Resident 98's electronic clinical record. The facility also provided an amended version of the CRNP progress note dated November 26, 2025, and signed on November 28, 2025, at 6:33 PM; this amended note was likewise not uploaded into the resident's electronic clinical record. During an interview conducted on January 30, 2026, at 12:30 PM, the above findings were reviewed with the nursing home administrator (NHA). The NHA explained that facility staff were temporarily covering the duties and responsibilities of the medical records practitioner while the facility was in the process of arranging consultative medical records services. These findings demonstrated that the facility failed to ensure Resident 98's clinical record was accurate, complete, and reliably maintained. Refer F55228 Pa. Code 211.5 (f)(ii)(iii)(iv)(x)(i) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on a review of facility policy, prior survey findings, the facility's Plan of Correction (POC), and observations made during the revisit survey, it was determined the facility failed to implement and sustain an effective Quality Assurance and Performance Improvement (QAPI) program that identified, monitored, and corrected ongoing deficient practice related to environmental cleanliness and maintenance. Findings included: Quality Assurance and Performance Improvement (QAPI), which is a systematic and ongoing process used by a facility to identify problems, implement corrective actions, and ensure those actions are effective and sustained over time, was reviewed. A review of the facility policy titled Quality Assurance Performance Improvement, last reviewed by the facility on January 23, 2026, revealed the facility will develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on outcomes of care and quality of life. The facilities' QAPI program shall address all systems of care and management practices, include clinical care, quality of life, and resident choices, utilize the best available evidence to design and measure indicators of quality, and have facility goals that reflect the process of care and facility operation that have been shown to be predictive of desired outcomes for residents and reflect the complexities of the services provided at the facility. A review of the survey completed January 30, 2026, revealed the facility was previously cited for failing to maintain a safe, clean, comfortable, and homelike environment throughout the facility whereas the facility failed to provide housekeeping services to maintain a clean and orderly environment throughout the facility. A review of the facility's submitted Plan of Correction (POC), which is the facility's written plan describing how it will correct identified deficiencies, prevent recurrence, and monitor ongoing compliance, with a completion date of March 10, 2026, revealed the facility implemented corrective actions that included cleaning identified areas, re-educating environmental services staff, conducting routine audits of resident rooms and common areas, and reporting audit results to the QAPI committee for ongoing monitoring and evaluation. However, observations conducted throughout the facility during the revisit survey on March 12, 2026, revealed continued concerns with environmental cleanliness and maintenance across multiple floors, including resident rooms, hallways, dining areas, and common spaces. These findings were consistent with previously cited concerns and demonstrated that corrective actions were not sustained. The continued presence of environmental concerns after implementation of the Plan of Correction demonstrated that the facility's QAPI program failed to effectively monitor the identified problem, analyze the underlying causes, and ensure that corrective actions were consistently implemented and maintained. The facility's QAPI monitoring activities failed to identify the recurrence of deficient practice related to housekeeping and maintenance and failed to ensure that previously implemented corrective actions resulted in sustained compliance with regulatory requirements. Refer F584 28 Pa. Code 201.18(e)(4) Management. 28 Pa Code 211.10 (c)(d) Resident care policies.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility-provided documentation, and interviews with staff and the resident representative, it was determined the facility failed to ensure that the resident representative was fully informed, in advance and in sufficient detail, by the physician or other practitioner, of the resident's condition, the risks and benefits of proposed treatment, and available treatment alternatives, in order to make an informed decision regarding care. This failure occurred for one of three closed records reviewed (Resident 98). Findings include: According to the National Institute of Health (NIH) and National Library of Medicine, Informed Consent is defined as the cornerstone of medicine, ensuring ethical treatment decisions and patient-centered care. Patients have the right to make informed and voluntary treatment decisions. Informed consent is more than merely a signature on a document; it is a communication process between the clinician and the patient. This process ensures that the patient is fully informed about the nature of the procedure or intervention, the potential risks and benefits, and the alternative treatments available. A clinical record review revealed Resident 98 was admitted to the facility on [DATE], with diagnoses that include chronic obstructive pulmonary disease (COPD, a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A clinical record review further revealed Resident Representative 1 was identified as Resident 98's responsible party/guarantor (the person legally and financially responsible for decisions and payment), substitute decision maker, and primary emergency contact. A review of Resident 98's admission agreement showed Resident Representative 1 signed the agreement on behalf of the resident. The admission agreement stated the facility's commitment to provide professional care and included resident rights, specifically the right to be fully informed in advance about care and treatment, to participate in care planning, and to be informed in advance of any changes in treatment. The agreement further stated the resident, or representative has the right to be informed, in advance and in understandable language, by the physician or other practitioner, of the risks and benefits of proposed care, treatment alternatives, and available treatment options, and to choose the preferred option. A review of Resident 98's admission agreement with the facility revealed Resident Representative 1 signed Resident 98's admission agreement as the resident representative. Further review of the admission agreement revealed the facility is committed to providing professional care and support services that will accommodate residents' medical and personal care service needs. By law you have the following rights: Freedom of Choice-Sec. 1919(c)(1): You have the right to be fully informed in advance about the care and treatment you will receive, to participate in planning your care and treatment, and to be fully informed in advance of any changes in your care plan or treatment. A review of Resident 98's admission agreement with the facility revealed section (c) Planning and Implementing Care. The resident has the right to be informed of and participate in his or her treatment, including: The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to his or her medical condition. The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The right to be informed, in advance, of the care to be furnished and the type of caregiver or professional that will furnish care. The right to be informed in advance, by the physician or other practitioner of the profession, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options, and to choose the alternative or option he or she prefers. A review of an external Advanced Practice Nurse (APN) notes dated November 25, 2025, at 7:19 PM, revealed Resident 98 was evaluated following a fall with head strike. An APN (a licensed clinician with advanced education and training authorized to assess patients and recommend medical treatment) conducted the assessment through clinical review and video (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation. The APN documented the resident's past medical history included dementia (a condition that affects memory, judgment, and the ability to understand and communicate information). The note indicated the resident experienced an unwitnessed fall from standing to the floor, striking her head, and was observed to have a golf-ball-sized mass on the head. The resident was noted to be taking aspirin (an antiplatelet medication that reduces the ability of blood platelets to stick together, which increases the risk of bleeding) and Plavix (another antiplatelet medication that also reduces platelet aggregation and increases bleeding risk). Examination findings, based on nursing assessment and video observation by APN, indicated the resident was alert and responsive and had a large, round mass approximately the size of a fist in the parietal area of the head (the side and top portion of the skull). The APN documented diagnoses of localized swelling, mass, and lump of the head and determined the resident required a computed tomography (CT) scan (a diagnostic imaging test that uses X-rays and computer technology to create detailed images of internal body structures) to rule out an acute intracranial hemorrhage (a life threatening condition involving bleeding inside the skull). The APN documented the condition was an acute new problem, assessed it as critical, recommended reevaluation of the resident's fall-risk care plan, and obtained physician orders for transfer to the emergency department. A review of a progress notes dated November 25, 2025, at 8:11 PM, documented the resident was in the dining room when the resident attempted to stand, became unsteady, and fell to the floor, striking the back of the head. The note documented the registered nurse supervisor was notified and assessed the resident. Vital signs were obtained, an ice pack was applied to the back of the resident's head, and neurological checks (routine monitoring for signs and symptoms of head or brain injury such as changes in level of consciousness, pupil response, strength, or sensation, were initiated. The nurse documented the resident's pupils were equal and reactive, the resident had full range of motion, and no signs or symptoms of pain or discomfort were observed at that time. The progress notes further documented that an external advanced practice nurse was notified and provided an order to transfer the resident to the emergency department for further evaluation. The note indicated the resident representative was informed of the order and declined the transfer at that time. However, the progress note did not document that the resident representative was informed the resident sustained a head strike, did not document the presence or size of any head injury or head mass, and did not document that the resident representative was informed of the potential seriousness of the resident's condition, including the risk of intracranial bleeding (bleeding within the skull). The note did not document that the resident representative was informed that the hospital transfer was ordered to allow diagnostic evaluation, including a computed tomography (CT) scan of the head, to assess for possible internal injury, nor did it document that the risks associated with refusing transfer following a head injury were explained. The progress note documented subsequent neurological checks were within normal limits. The resident was seated in a chair at the nurse's station for closer observation, and the note indicated the resident would continue to be monitored for the remainder of the shift. During a phone interview on January 30, 2026, at 11:42 AM, Resident Representative 1 explained that the facility contacted her on November 25, 2025, to inform her that Resident 98 had fallen and that an APN wrote an order to send the resident to the emergency department. Resident Representative 1 indicated she was informed that the facility did not think there was a need to send the resident to the emergency department. She further stated she was not informed that the resident struck her head, developed a fist-sized mass, was considered critical, or that the transfer was recommended to rule out a potentially life-threatening intracranial hemorrhage. During an interview on January 30, 2026, at 12:05 PM, Employee 4, Licensed Practical Nurse, stated she contacted Resident Representative 1 on November 25, 2025, to report the fall and the APN's order for emergency department transfer. Employee 4 was unable to provide documented evidence that she communicated the critical assessment, head injury findings, size of the mass, or the specific risks associated with declining transfer, including the need for a CT scan to rule out intracranial bleeding. Review of the clinical record confirmed there was no documentation that this information was (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communicated. During an interview on January 30, 2026, at 12:30 PM, the Nursing Home Administrator (NHA) reviewed the above information and was unable to provide documentation demonstrating the facility ensured Resident Representative 1 received sufficient, detailed information to make an informed decision regarding treatment options following the fall. Specifically, there was no documented evidence the facility communicated the APN's findings that the resident's condition was critical, involved a significant head injury, and required emergency evaluation to rule out intracranial hemorrhage. During an interview on January 30, 2026, at 12:30 PM, the above information was reviewed with the Nursing Home Administrator (NHA). The NHA was unable to provide documented evidence the facility provided detailed information to Resident Representative 1 to make an informed decision about Resident 98's treatment options after the fall on November 25, 2025. Specifically, there was no documented evidence the facility communicated the APN's findings that the resident's condition was critical, involved a significant head injury, and required emergency evaluation to rule out intracranial hemorrhage. The facility failed to ensure the resident representative was fully informed of the risks, benefits, and treatment alternatives, as required, prior to declining the recommended transfer to the emergency department, thereby limiting the resident representative's ability to make an informed decision regarding Resident 98's care. Refer F842 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.2 (d)(7) Medical director. 28 Pa. Code 211.12 (c)(d)(1)(3) Nursing services.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, and staff interviews, it was determined the facility failed to ensure physician orders accurately reflected a the resident's documented resuscitation status for one of 23 residents reviewed (Resident 73). Findings include: A review of a facility policy titled Residents' Rights Regarding Treatment and Advanced Directives, last reviewed by the facility on [DATE], revealed it is the facility policy to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate and advance directive. An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to the provision of health care when the individual is incapacitated. Review of the clinical record revealed that Resident 73 was admitted to the facility on [DATE], with diagnoses to include malignant neoplasm of the right breast (breast cancer) and vascular dementia (a decline in thinking, memory, and cognitive skills caused by reduced or blocked blood flow to the brain, which deprives the brain cells of oxygen and nutrients). Review of the resident's current physician orders at the time of the survey ending [DATE], revealed an order identifying the resident's code status as Full Code, indicating cardiopulmonary resuscitation (CPR) was to be initiated in the event of cardiopulmonary arrest (if breathing stops or if the heart stops beating). The resident's electronic health record also reflected the status of Full Code. Further review of the clinical record revealed a completed and signed Physician Orders for Life Sustaining Treatment, or POLST (a form designed to improve resident care by creating a portable medical order form that records the resident's treatment wishes so that emergency personnel know what treatments the resident wants in the event of a medical emergency, taking the resident's current medical condition into consideration) dated [DATE], indicating the resident elected CPR and attempted resuscitation. Review of nursing documentation dated [DATE], at 12:31 AM indicated the resident was admitted to hospice services (end of life care). The documentation stated the resident's son was aware and would be coming to the facility later that day to complete the Do Not Resuscitate (DNR, a medical order directing that cardiopulmonary resuscitation, a life-saving procedure performed when the heart or breathing stops, should not be attempted) paperwork to change the resident's code status. Review of social services documentation dated [DATE], at 6:33 PM indicated the resident's son met with the Certified Registered Nurse Practitioner and hospice staff and expressed that he did not want aggressive treatment for his mother due to her diagnosis of breast cancer. The note further stated confirmation was obtained from the hospice social worker that the resident's code status had been changed to DNR upon admission to hospice on [DATE]. Despite documentation indicating the resident's code status had been changed to DNR, the resident's electronic health record, POLST, and physician orders continued to reflect Full Code status. During an interview on [DATE], at 11:10 AM the Director of Social Services provided the surveyor with a Do Not Resuscitate document signed by the resident's son on [DATE], and by the physician on [DATE]. The Director of Social Services confirmed that the resident's change in code status from Full Code to DNR was not implemented after the physician signed the DNR order. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.5 (f)(i) Medical records. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services. 28 Pa. Code 211.10 (c)(d) Resident care policies.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and a staff interview, it was determined the facility failed to timely complete a significant change Minimum Data Set assessment for one of 23 residents reviewed (Resident 8). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2025, indicated that a significant change MDS assessment is required to be performed when a terminally ill resident enrolls in a hospice program. The assessment reference date (ARD) must be within 14 days from the effective date of the hospice election (which can be the same as or later than the date of the hospice election statement, but not earlier than). A significant change MDS assessment must be performed regardless of whether an assessment was recently conducted on the resident. A clinical record review revealed that Resident 8 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). A clinical record review revealed Resident 8 was admitted to hospice care (a program for terminally ill persons where an array of services is provided for the management of terminal illness and related conditions) related to end-stage dementia on January 12, 2026. Further clinical record review revealed no documented evidence that a significant change of status MDS assessment was initiated or completed following Resident 8's enrollment in a hospice program until inquiries were made during the week of the survey ending on January 30, 2026. During an interview on January 29, 2026, at 12:48 PM, the Registered Nurse Assessment Coordinator (RNAC) confirmed that a significant change in status MDS was not completed within the required 14-day timeframe after hospice care was initiated for Resident 8.28 Pa. Code 211.5(f)(x) Clinical records. 28 Pa. Code 211.12(d)(3) Nursing services		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, select policy review, and staff interview, it was determined the facility failed to maintain an environment free from accident hazards for one of 23 sampled residents (Resident 5). Findings include: A review of the facility's Medication Administration policy, reviewed January 23, 2026, revealed that when administering medications to a resident, staff are to observe consumption of the medication. Clinical record review revealed that Resident 5 was admitted to the facility on [DATE], with a current diagnosis of diabetes (a chronic condition causing high blood sugar because the body cannot produce enough hormone to lower the levels to a normal range), chronic pain, and iron deficiency (low iron levels in the blood). A quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) completed on October 28, 2025, revealed the resident had a BIMS of 3 (Brief Interview for Mental Status, a tool to assess cognitive function. A score of 0-7 indicates severe cognitive impairment). An observation of Resident 5's room on January 27, 2026, at 11:05 AM, revealed a clear plastic medication cup placed on top of the bedside cabinet containing two unsecured tablets, identified as one white oblong tablet and one round black tablet. The medications were readily accessible within the resident environment and were not secured or supervised by staff. An interview with Employee 7 LPN (license practical nurse) on January 27, 2026, at 11:15 AM, confirmed the two tablets were medications that belonged to Resident 5. Employee 7 indicated that the medications inside the cup were an iron tablet (a round black tablet administered for low levels of iron in the blood) and Tramadol (opioid medication given for pain). Employee 7 stated the medications had last been administered together on January 26, 2026, at 1:00 PM and acknowledged the medications should not have been left unsecured in the resident's room. The employee further confirmed that staff were required to verify medication consumption prior to leaving the resident. Leaving medications unsecured in a resident's room created a potential accident hazard, particularly given the resident's severe cognitive impairment, as the resident could ingest medications inappropriately, ingest duplicate doses, or the medications could be accessed by other residents, visitors, or staff, placing others at risk for unintended exposure. An interview with the Director of Nursing on January 27, 2026, at 11:45 AM, confirmed that nursing staff failed to observe and verify Resident 5's medication consumption and that medications should not be left unsecured in resident rooms 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing service. 28 Pa. Code 211.10 (c)(d) Resident care policies.		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policies, and staff interviews, it was determined the facility failed to develop and implement individualized, person-centered interventions to manage dementia-related behavioral symptoms in order to promote resident safety and to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one resident out of 23 residents sampled (Resident 7). Findings include: A review of the facility policy titled Dementia Care last reviewed by the facility on January 21, 2026, indicated the facility will provide appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being. The facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach. The care plan interventions will be related to each resident's individual symptomology and rate of dementia progression with the end result being noted improvement or maintained of the expected stable rate of decline associated with dementia. Review of the facility policy titled Behavioral Assessment, Intervention and Monitoring last reviewed by the facility on January 21, 2026, indicated behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. The IDT (interdisciplinary team) will evaluate behavioral symptoms to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Interventions will be individualized and part of an overall care environment, and will be based on detailed assessments of physical, psychological and behavioral symptoms and their underlying causes. A review of the clinical record revealed that Resident 7 was admitted to the facility on [DATE], with a diagnoses of dementia with mood disturbance (irreversible, progressive degenerative disease of the brain, resulting in a decline in memory, reasoning, language, and functional ability which also involves emotional changes like depression, anxiety, apathy, irritability, or sudden mood swings), and anxiety disorder (a mental health condition characterized by intense, persistent, and excessive worry or fear that significantly interferes with daily life). A quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated December 9, 2025, revealed that the resident was severely cognitively impaired with a BIMS score of 3 (Brief Interview of Mental Status, a screening tool to evaluate cognitive function; a score of 0-7, indicates severe cognitive impairment). A review of the resident's current care plan dated June 12, 2025, identified a problem area of dementia. Planned interventions included staff conversing with the resident during care, ensuring activities were compatible with the resident's physical and cognitive abilities, identifying the resident's prior interests and activity involvement through discussion with the resident and family, introducing the resident to peers with similar backgrounds, and providing activities of interest. The care plan also identified elopement (when a resident who is incapable of adequately protecting himself, departs from a secured area or the facility premises undetected without staff authorization, knowledge, or supervision) as a problem area, with planned interventions to apply the use of a Wander Guard device (wearable bracelet and door sensors to prevent residents from elopement), development of an activity program to divert attention, follow elopement protocol if resident was missing, and redirecting the resident when wandering in a potentially unsafe area. A review of nursing documentation from June 7, 2025, through January 27, 2026, revealed multiple documented episodes of dementia-related behavioral symptoms, including intrusive wandering into other residents' rooms; rummaging through and removing other residents' personal belongings; physically taking items from other residents' hands; removing items from medication carts; verbal aggression toward staff and residents; physical aggression including striking staff and throwing objects; refusals of care; and refusal of weights. Despite the ongoing and escalating behavioral symptoms, there was no documented evidence as of (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the survey ending January 30, 2026, that the facility developed or implemented specific, individualized interventions or diversional strategies to address the resident's dementia-related behaviors. Additionally, the resident's dementia care plan failed to identify and address the specific behaviors exhibited, including intrusive wandering, misappropriation of other residents' belongings, physical and verbal aggression, throwing objects, and verbal threats. The care plan also failed to include individualized, behavior-specific interventions for staff to implement in response to these behaviors. The facility failed to develop and implement an individualized, person-centered, interdisciplinary plan of care to identify, manage, and reduce the resident's dementia-related behavioral symptoms, placing the resident and others at risk for harm and failing to support the resident's highest practicable well-being. During an interview on January 30, 2026, at 9:45 AM the Assistant Director of Nursing confirmed the facility failed to demonstrate the development and implementation of individualized, person-centered interventions to address Resident 7's dementia-related behaviors. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10 (c)(d) Resident care policies 28 Pa. Code 211.12 (d)(3)(5) Nursing services.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interview, it was determined the facility failed to ensure the provision of adaptive dining equipment as prescribed to support safe eating for one of 23 sampled residents. (Resident 16) Findings include: A review of the clinical record revealed that Resident 16 was admitted to the facility on [DATE], with diagnoses to include cerebral palsy (group of permanent movement, muscle tone, or posture disorders caused by abnormal brain development or damage before, during, or shortly after birth) and dysphagia (difficulty swallowing). Review of a quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 2, 2025, indicated that a BIMS interview (Brief Interview for Mental Status, a tool to assess cognition) should not be completed with the resident due to the resident being rarely or never understood, had short term and long term memory problem, was severely cognitively impaired for decision making, and was dependent on staff for eating. A physician order dated April 4, 2024, noted an order for a coated spoon (protects teeth and prevents minor injuries to the gums and lips) with all meals. Review of Resident 16's January Task Documentation Report between the dates of January 1, through January 28, 2026, revealed the coated spoon was not provided with meals for 31 out of 84 meals served. Observation during the lunch meal on January 29, 2026, at 12:30 PM revealed a coated spoon was indicated on the resident's tray ticket. However, a plastic disposable spoon was provided on the resident's tray. Interview with Employee 9 Nurse Aide at this time confirmed the coated spoon was not provided. Employee 9 confirmed the coated spoon was frequently not provided on the resident's tray. Employee 9 revealed the resident at times bites down on the spoon while feeding and having the coated spoon is beneficial to the resident. During an interview on January 29, 2026, at approximately 1:30 PM the Nursing Home Administrator acknowledged the facility failed to ensure the prescribed adaptive equipment (coated spoon) was consistently provided to the resident with meals and used in accordance with the physician's orders. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of the facility admission agreement and arbitration documents, and staff interviews, it was determined the facility failed to ensure arbitration agreements were implemented to ensure that an arbitration agreement allowed for the mutual selection of a neutral arbitrator for one resident out of three discharged residents reviewed. (Resident 98). Findings include: A clinical record review revealed Resident 98 was admitted to the facility on [DATE]. A review of an admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 13, 2025, revealed that Resident 98 is severely cognitively impaired with a BIMS score of 02 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 00 to 07 indicates cognition is severely impaired). A clinical record review revealed Resident Representative 1 is indicated as Resident 98's A/R guarantor (accounts receivable guarantor a person or entity that formally accepts legal and financial responsibility for paying a debt), substitute decision maker, and emergency contact. A review of Resident 98's admission agreement revealed Resident Representative 1 signed all admission documents on behalf of the resident on November 6, 2025. Included in the admission packet was an arbitration agreement titled Agreement to Resolve Legal Disputes through Binding Arbitration. Binding arbitration is a private dispute resolution process in which parties waive their right to a court trial and instead agree to have disputes decided by an arbitrator whose decision is final and legally enforceable. Further review of the arbitration agreement dated November 6, 2025, revealed the agreement did not allow the resident representative and the facility to mutually agree upon a neutral third-party arbitrator. Specifically, Section C, Who will conduct arbitration, identified a pre-selected arbitrator chosen solely by the facility and listed the arbitrator's name, address, and contact information, without offering the resident or resident representative an opportunity to participate in the selection process. During an interview conducted on January 30, 2026, at 9:30 AM, the Director of Social Services reviewed the arbitration agreement and acknowledged the language was incorrect. The Dire of Social Services indicated the facility had since revised the arbitration form to allow for the selection of a mutually agreed-upon neutral arbitrator and indicated the facility planned to review all arbitration agreements to ensure fairness. During an interview on January 30, 2026, at 12:30 PM, the above information was reviewed with the Nursing Home Administrator (NHA). The NHA was unable to provide documented evidence that Resident Representative 1 was provided with a binding arbitration agreement that allowed for the selection of a mutually agreed upon neutral arbitrator. The facility failed to ensure a neutral and fair arbitration process by ensuring both the resident representative and the facility agree on the selection of a neutral arbitrator. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29(a) Resident rights.		